THE HOSPITAL GAZETTE

AND

ARCHIVES OF CLINICAL SURGERY,

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CONTENTS.

EDITORIAL.—Health Officer of the Port, [70.] LECTURES.—Lectures on Paralysis and Convulsions as Effects of Organic Disease of the Brain; by C. E. Brown-Sequard, M. D., Etc. Lecture VI., [49.] Clinical Lecture; by T. Gaillard Thomas, M. D. I. Laceration of the Cervix Uteri, [57.] II. Hæmorrhage after Abortion, [60.] III. Pruritus Vulvæ, [62.] ORIGINAL ARTICLES.—Remarks on Hysteria; by Frank P. Foster, M. D., [64.] HOSPITAL RECORDS. —*Roosevelt Hospital, New York; Reported by Dr. W B. Berry.* Ligation of Femoral Artery for Aneurism of Femoral—Lister's Antiseptic Method, [68.] PERISCOPE.—HUGHLINGS JACKSON on the Relations of Ophthalmology to General Medicine, [DR. ST. JOHN,) [73.] Pigment of the Retina, (DR. ST. JOHN,) [74.] GALEZOWSKI on Optic Neuritis from Lead Poisoning, (Dr. St. John, [75.] VEREBELYI on Treatment of Congenital Club-Foot by Subperiosteal Removal of the Astragalus, (DR. SHAFFER,) [76.] PIROGOFF'S Operation for Club-Foot, (DR. SHAFFER,) [76.] ERRATA, [76.]

LECTURES.

LECTURES ON PARALYSIS AND CONVULSIONS AS EFFECTS OF ORGANIC DISEASE OF THE BRAIN.

Delivered at Bellevue Hospital Medical College.

BY

C. E. BROWN-SEQUARD, M. D., ETC.

LECTURE VI.

GENTLEMEN—In the last lecture I pointed out to you the symptoms that are generally found when the paralysis occurs from disease in the cerebellum. To-day, I have to conclude with what relates to that question. You may remember that I said there was very frequently, in such cases, a disorder in the movements of the body. I characterized them as being similar to what is observed in a drunken man. One observer, taking into account the experiments of Ferrier, endeavored to show that the centres for the movements of the eyes are located in the cerebellum. He thought that if disease in the cerebellum produced disordered movement, it was due to lack of power in the eye. The movements of the eye become irregular and disordered, and a man who sees objects continually shaking before him, has disorder in his movements. This peculiar condition of disordered movements cannot be explained in this way. If it were due to such a cause, it would cease as soon as the eyes were closed, for then the impression of the shaking of objects would be lost, and consequently be without effect. In most cases there cannot be such an explanation, as there is no such pretended relation. These conclusions, as to the explanation of the disorder in movements, have been arrived at from Ferrier's experiments on the electrization of the cerebellum in animals.

Ferrier has not paid attention to a fact which always occurs in experiments of this kind. The movements seen in electrization are due to an irritation carried from the point to which the stimulus is applied. The action is caused in a reflex manner. The same sort of thing occurs when the sole of the foot is tickled. When we irritate that part, certain muscular movements occur in the face, but we do not conclude from that fact, that the centre for those movements is situated in the sole of the foot. The same reasoning leads us to deny that because galvanism of a certain portion of the cerebellum causes movements in the eyes, that the centre for their movements is situated there.

In order to establish the existence of a centre for special actions, we should be able to show that not only galvanism, but all other modes of irritation or excitation will produce the same action, and furthermore, when the brain is destroyed, or the part is taken away with a knife, we should get a cessation of the movements.

I have found in six or seven hundred cases of cerebellar disease no trouble whatever with the eye; only in a trifling number of cases is there trouble with the eye. Cases vary greatly, in some there is spasm of the recti muscles, in others there is something else, and there are a great many kinds of difficulty. It is certain, however, that a peculiar disorder of movements is frequently observed in disease of the cerebellum.

There are two other peculiar features observed as regards disorder of movements in disease of the cerebellum. These are just the opposite of each other, one being a tendency to run forward, and the other being a tendency to run backward. There are cases reported of tubercles situated in the centre of the cerebellum, in one of which the patient had a tendency to run forward, and in the other there was a tendency to run backward. Now you cannot in one individual locate in that spot the centre for forward movements, and in the other the centre for backward movements in the same place, and as, besides, in disease of the same part of the brain a variety of symptoms may occur, you cannot say that there exist centres for forward, or backward, or side movements.

So it is with the rotatory or circular movements. You can find all of these peculiar aberrations of movement in disease of other parts of the brain, although, it is true, some of them are found most frequently in disease of the cerebellum. The rotatory movement occurs more frequently in disease of the pons Varolii where the crus cerebelli enters it, or in the crus cerebri. These portions have more power of producing this movement than the cerebellum. Disease of the supra-renal capsule has been known to produce this description of movement. Disease of the auditory nerve, with or without organic disease of the brain, has been known to produce it, as in the celebrated case of the Duke of Wellington. He was suffering from some trouble with the ear, and a quack injected into it a solution of nitrate of silver. The next day he was seized with this affection and continued to roll round and round in his bed.

But to continue with what I have to say of the symptoms that coexist with disease in the cerebellum. There is a fact of considerable interest concerning the sexual organs. It has been said that the cerebellum is the centre for the sexual apparatus. It is certainly true that in some cases of disease we find a loss of sexual power, but we may, on the other hand, see exactly the reverse of this condition present. An inflammation in the centre of the cerebellum may cause either loss or increase of the sexual power. The conclusion that there is no relation between the sexual power and the cerebellum comes out even more clearly when you see that no change whatever may appear in this function when there is extensive disease of the cerebellum.

In one of the most remarkable cases that I know of, of disease of the cerebellum, that recorded by Dr. Combette, there was no trace of disorder of movements, or inability to stand or walk. In this case the disease was located in the cerebellum and its attachments. There was no loss of sexual appetite, but, on the other hand, an enormous increase. If the organ were in connection with, or had control of the sexual apparatus, something quite different should have occurred. The patient was a young girl who was intensely addicted to masturbation. The result was not due to an irritation of the organ, as there was no organ there to be irritated. We cannot say that the symptom was due to such a cause, as the cerebellum was completely absent. The views, then, as regards the presiding power of the cerebellum over the sexual apparatus cannot be entertained.

Another most important point relates to the paralysis itself. If the cerebellum has any particular function, it is the organ that serves for the production of nerve force. The only thing that is at all constant in disease of this organ is a diminution of the strength. This loss of strength exists in all parts of the body, whether the disease is situated in one-half or the other of the cerebellum, or in the middle.

The variety of paralyses that occur in disease of the cerebellum is extremely great. There is no doubt, however, that in most cases there is a localized paralysis. Paralysis may be due in some of these cases to pressure on the pons Varolii exerted by the lesion in the cerebellum. Almost invariably in these cases, the paralysis is on the opposite side of the body. We find such results particularly when the leison in the cerebellum is of such a nature as to cause pressure, as a hæmorrhage or a tumor of considerable size that presses on the pons Varolii. In such cases the paralysis is due in reality to disease of the pons Varolii, and only apparently to the disease in the cerebellum.

Sometimes paralytic symptoms appear in cases where there is but very limited disease in the cerebellum, as a slight softening. In such cases paralysis cannot be due to pressure on the pons Varolli, and there is no doubt whatever that paralysis may appear where there is no degree of pressure whatsoever.

There may be, in rare instances, paralysis of the face, or the tongue, or the whole body, but as a rule, in hemiplegia allied with disease of the cerebellum there is no paralysis of the tongue or of the face. In these facts lie the principal points of diagnosis. If a patient be suddenly struck down with apoplexy and has a strong hæmorrhage, if he have hemiplegia, difficulty in breathing, coma, and loss of consciousness, we have here the symptoms usually occurring in hæmorrhage in some part of the encephalon. If we find no paralysis of the face or tongue, and when the patient recovers from the first effects of the stroke he has vomiting, amaurosis, etc., we may usually consider that the hæmorrhage has occurred in the cerebellum. When the patient has recovered sufficiently to get up, and when he walks, we notice that besides his hemiplegia, he has disorder of the movements, we are still further led to think that the disease is situated in the cerebellum.

Professor Andral has pointed out perhaps more forcibly than any one else, that disease frequently coexists on one side of the brain, and on the other side of the cerebellum. In such cases the paralysis that occurs is almost always situated on the side of the body in which the disease located in the brain would produce it, viz., usually the opposite. This is almost always the case when there is a lesion on one side of the brain and the other side of the cerebellum. There is an exception sometimes when we find tubercles scattered on the right side of the brain and the left side of the cerebellum, and in some of these cases we have paralysis on the right side of the body, contrary to Andral's rule.

Another feature is extremely interesting. When atrophy is found consequent on disease of the brain, we almost always find some in the cerebellum on the opposite side. We shall have to pay more attention to this in the future than in the past, as much that will prove of interest will be found in this fact of connection.

Now let us pass to the crura cerebri, parts above the pons Varolii at the base of the brain. They are composed of a great nest of fibres going through them to enter into the corpora striata and optic thalami, or to go directly to the convolutions of the brain. This part certainly is full of interest. It is quite certain that the crus on each side is, according to the prevalent theory, the only bond establishing connection between the same side of the brain and the opposite side of the body. As everything is narrowed down, then, to one particular location, what pathology shows us in regard to disease of this portion is far more important than what relates to other parts. There is no possibility of escaping from the conclusions to be drawn from these facts. All the fibres serving for voluntary motion pass here, those from the right side of the brain in the right crus, and those from the left side of the brain in the left crus. This is in accordance with the generally admitted theories.

If these theories were right, when there is disease in a small part of the crus, striking only a few fibres of the many that compose it, say the outside fibres, the paralysis should be limited accordingly. If these fibres are really what they are imagined to be, going straight to the muscles after having passed through cells in the medulla oblongata and spinal cord, we should always see the paralysis limited entirely to certain muscles. It might be paralysis of the arm or leg, or only a few muscles of the arm or leg might be involved. Now such is not the case at all. There are a great many cases of disease located in the crus and having destroyed the fibres in different parts. A paralysis, if it exists, should be seen in those muscles receiving their nerves from the particular part of the crus that is the seat of the disease, and chiefly on the opposite side of the body. In by far the vast majority of cases the paralysis is more extensive than it ought to be, taking into consideration the extent of the lesion. You may find paralysis of one arm or of one leg only from disease in the crus cerebri, but do not therefore believe that any particular fibres are destroyed, as we may find the same paralysis of the arm alone when the disease is elsewhere in the crus, or even in the whole of the crus. There is no connection between the seat and extent of the paralysis and the location and limit of the lesion in the crus.

There are cases where there is no paralysis at all following disease in the crus cerebri, as in the case of abscess of Jackson of Boston. There are cases where the whole of the crus has been destroyed, and there has been a complete absence of marked paralysis. Still more, there are cases—four to my knowledge, one by Mason—in which disease in the crus cerebri produced paralysis on the corresponding side of the body. So that in this organ, as well as in other parts of the brain, we see facts that are entirely inconsistent with the old views. We see no paralysis where there ought to be paralysis, or we see paralysis where it ought not to exist, or we see paralysis on the wrong side of the body, although it ought always to be on the side of the body opposite to the side of the brain on which the lesion exists, according to the old theories.

There are five cases to my knowledge in which both crura cerebri were destroyed without giving rise to any marked paralysis.

From an examination of all these facts, you must be led to admit what I have already said, that very few fibres are necessary to establish the connection between the will power and the muscles.

The symptoms of disease in the crus cerebri are quite interesting to study. The third pair of nerves which moves a great many muscles of the eye is affected almost necessarily in disease of the crus cerebri, unless the disease is situated in the back part. Dilatation of the pupil results as a consequence of paralysis of the constrictor muscle. There is also strabismus, owing to the persistent action of the sixth pair of nerves. In a considerable number of cases there is diplopia. There is paralysis of the elevator of the eyelid which is innervated by a branch of the third pair, and so we have ptosis. So you generally find ptosis, strabismus, diplopia, dilatation of the pupil, etc., existing when the disease is situated in the crus cerebri, and these points will help you in the diagnosis.

If the disease is situated in the back part of the crus cerebri, the third nerve may escape, and then these symptoms will be wanting.

It has been supposed that the conductors of sensation, likewise, in going to the brain, pass through the crura cerebri. This idea is radically false, as they may be destroyed without any loss of sensation. In one case hyperæsthesia occurred.

There are some other features which may lead you to the diagnosis of disease in this place It is in the neighborhood of the passage of the fibres of the optic nerve, and so you may get derangement of vision. Where the tubercula quadrigemina are involved, you frequently see amaurosis. In three or four cases I have seen hemiopia. From these symptoms you may have means of diagnosis in many cases where the disease is in the crus cerebri on either one or the other side.

The tubercula quadrigemina are frequently injured when the disease is situated in the crus, and they have been considered as centres for vision. They have, certainly, a power over vision, but they both may be diseased without any amaurosis, or one may be diseased alone, and produce amaurosis in both eyes. There is then no necessary connection between them and the power of vision, but in the majority of cases we are able to say that when they are diseased we get certain changes in the power of vision. Fortunately, by a complete analysis of the symptoms occurring in brain disease, we can often come to a correct diagnosis.

Disorder of movements may exist when the tubercula quadrigemina are diseased, the same as occurs in disease of the cerebellum, but in this case the symptom is usually less marked. When the eyes are closed the patient cannot stand on one foot. We also find this condition present in disease of other parts, but most frequently it is due to disease here. This fact led Cocks, and other physiologists, lately to conclude that the tubercula quadrigemina were centres for the muscular sense. This is not so, as in many cases of disease of these organs there is no lack of the balancing power.

To pass now to other parts. There are two large ganglia, or rather part of one and the whole of another, that protrude into the lateral ventricles. One of these is the corpus striatum, which consists of two parts, the intra-ventricular and the extra-ventricular. They had always been considered as voluntary motor centres up to the time of the experiments of Fritsch and Hitzig, who have thrown physicians into the belief that the centres are located in the convolutions. Todd, Carpenter, and most others look on the corpora striata as voluntary motor centres, but here again I am obliged to dissent from these accepted views. I now speak of the intra-ventricular portion of the ganglion. Disease here, if the part were, as is believed, employed in moving the muscles, if it produced irritation, would cause convulsions to be manifested.

Now the truth is that irritation of no other part of the brain has so little power of producing convulsions. This is a decisive fact that shows that it is not a voluntary motor centre. It is said to be in connection with other parts, which, when excited, are supposed to give rise to convulsions. According to recent views, it has not been stripped of its power as a centre. It is supposed to be a place of passage for the voluntary motor fibres where they acquire new strength, being in connection with new cells which add fresh power to their functional activity.

In reality, we find cases of destruction of the corpus striatum without any paralysis at all, or at least without any marked paralysis. There is no relation as regards the duration, extent, and degree of the paralysis and the lesion in the corpus striatum from which it resulted. There are cases in which the disease was exceedingly slight and limited to a minute part of this portion of the brain, with, however, a persistent paralysis up to the time of death, and moreover of a severe character. The facts observed, are then in decided opposition to the theory.

Hughlings Jackson holds very properly, that one small part of this portion of the brain could alone perform the functions of the whole organ. He knew very well that a great portion of it could be destroyed, and that the function might yet remain, but when we find *all* of it destroyed, and still no paralysis or loss of function, why then there is an end to the theory.

Still more, we find disease occupying the intra-ventricular portions of both corpora striata without any paralysis. There is not one such case alone, but a great many like cases.

The corpora striata have no specific signs by means of which we can recognize the locality of the lesion, but we have some signs by which we can suspect its presence there. Hæmorrhage here is by far more frequent than in any other part of the brain, except perhaps in the optic thalami. There is also another exception to this generality, but perhaps it can hardly be called an exception, and that is, that it is also almost as frequent between these two ganglia, the corpora striata and the optic thalami. That peculiar condition that Charcot described as miliary aneurism is extremely common in the blood-vessels in this location, and this is the cause of the frequency of hæmorrhage in this location—that is, in the corpora striata and optic thalami, and between the two ganglia.

If you have paralysis of one side of the body, and symptoms of hæmorrhage in the brain, in this mere fact alone there is a supposition that the disease is situated in this region. Other symptoms of disease in the brain, such as paralysis of the third pair of nerves, the existence of amaurosis, symptoms in which the patient shows a tendency to go round and round, or forward, backward, or sideways, or execute particular movements, are by far less frequent when the disease is situated in the corpora striata, than they are when the disease is situated in other parts. Vomiting occurs less frequently in disease here. There may be hyperæsthesia in many instances. By passing in review all the symptoms known to be more frequent in disease of the base of the brain, and knowing that a lesion here is not so apt to produce these symptoms, we may most often come to the right conclusion, especially will this be the case if there are no convulsions.

This leads me to speak of the optic thalami, disease in which, will produce convulsions very frequently. It may also cause paralysis, and here again we come into conflict with the generally accepted views regarding the physiology of this organ. According to these theories it is not considered as assisting in voluntary movements, but paralysis comes on just as frequently from disease here as from disease in the corpus striatum or in other parts. These facts are highly in favor of the views I have given you, and decidedly against the view that paralysis arises from the destruction of centres or conductors.

In disease in the optic thalamus there is a great change in the reflex faculty in the limbs, when they are paralyzed, or even when they are not much or not at all paralyzed. It disappears entirely, or is much diminished, or just the contrary, there may be a condition in which the reflex faculty is increased.

There is still another feature of interest. There is often paralysis of the blood-vessels on the opposite side when the disease is situated in the optic thalamus. Not that I consider the optic thalamus as a centre for the vaso-motor system, but, nevertheless, the clinical fact exists. There is a dilatation of the blood-vessels, and a heightened temperature of the part. This is the reverse of what you usually find in disease of the pons Varolii, in which latter case, the limbs of the opposite side are found to be colder.

The optic thalamus is certainly a most interesting organ, and I wish I could dwell upon it more at length. There are few that are so extremely interesting. Very frequently, disease here is the cause of amaurosis. Still more, there may be loss of the senses on one side, generally on the opposite side, very similar to the conditon produced by division of the trigeminal nerve as described by Magendie. The loss of senses is slowly produced, generally on the opposite side, and it differs from division of the trigeminal in that respect.

What is more remarkable still, we have an alteration in the structures of the eye. This has occurred in two cases to my knowledge, and I dare say it has done so in more. In these cases, the trigeminal nerve was apparently healthy, so that there is, then, a great resemblance between its properties and those of the optic thalamus. It has been considered as the centre of sensation, but many new observers have given up the views of Todd and Carpenter. In the neighborhood, but not inside of the optic thalamus, is the channel of passage of the fibres serving for the perception of sensation. These fibres go to the posterior lobes of the brain, but we very frequently find destruction of the posterior lobes without any anæsthesia.

We will pass now to another part of the brain, that is, the radiation of the fibres to the convolutions on the external surface. This part constitutes the centrum ovale. Disease in this portion of the cerebral lobes can produce paralysis, and the paralysis may be just as great as the paralysis produced by disease anywhere else in the brain, and there is this remarkable fact that the disease may be situated in the most distant and distinct parts and still give rise to the same kind of paralysis. Disease in the anterior, middle or posterior lobes can produce paralysis.

Disease in any part can produce complete paralysis on the opposite side of the body. If the disease here is limited in extent, can it be that all of the fibres are destroyed? Where the paralysis is complete and the casual lesion is limited, the facts cannot be reconciled. In such a case, the paralysis should be slight or local, but I repeat that complete persistent paralysis is often present.

In the cases of Porta and others, all of this portion of the brain has been destroyed without any paralysis at all.

There follows necessarily, also in the examination of these facts, a series of proofs against the views generally admitted. Paralysis or convulsions may be on the corresponding side to the lesion, or on the opposite, but in one out of every three hundred cases the paralysis will be on the same side. Not so, however, with convulsions. You will find them as frequently on one side as on the other when only the white fibres are diseased. Paralysis cannot then be owing to a destruction of fibres conducting the impulses from the will power to the muscles.

CLINICAL LECTURE.

Delivered at the College of Physicians and Surgeons, New York,

BY

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I. LACERATION OF THE CERVIX UTERI. II. HEMORRHAGE AFTER ABORTION. III. PRURITUS VULVÆ.

GENTLEMEN—Of the cases I shall show you to-day you may, perhaps, have seen many examples before in this clinic; but this must not discourage you. You must always keep distinctly in mind what is the object of a clinic like this. You come here to make yourselves familiar with cases that you are likely to meet with in ordinary practice, and not with those that you may, perhaps, never be called upon to treat. I am sure that if I had been going to perform gastrotomy today every seat before me would have been filled, and naturally; but you come to see such operations as a sort of curiosity. The time of a clinic like this, however, should be occupied by the exhibition of such cases as you will often see in your office, and that you may be called upon any day to treat. It is true that your text-books tell you how to treat these cases, but only in a certain way. You are not brought face to face with the case, as you are in a clinical lecture, where the case and the treatment are so closely brought into apposition. I need, then, make no further apology for showing you a certain class of cases frequently.

The first patient is Mrs. Mary F., aet. 34, a native of the United States; married nine years. She has had three children and no miscarriages. The last child was born five years ago, and she has never been well since. Now, in hearing this history, there are two points that ought to make an impression on you at once. She has been married nine years, and has borne three children, all three of which were born in the first four years of married life; but, for the last five years, the greater portion of the time, she has been sterile. This is a curious fact, to say the least. The second point is this, that her last child was born five years ago; from that particular time she has never been well. The inference must be, that something occurred at her confinement to make her an invalid, and prevent her bearing any children afterward.

Up to that time she had been pretty well, suffering only occasionally from a little weakness. Now, let us inquire into what the trouble has been since that time. She says that for two or three days before the commencement of her menses she suffers from pain. Sometimes these pains are relieved when the flow is established, but sometimes they continue, though in a less degree, during the flow. She further complains of a constant backache, and a continual leucorrhœal discharge, of a slimy, yellowish substance. This discharge irritates the parts considerably.

The history is a short one, and the patient has but very few symptoms to be relieved. They are very clear, and she comes here to have them removed. Let us recapitulate them: *First*—Sterility of five years' duration. *Second*—Profuse leucorrhœa. *Third*—A fixed backache; and *Fourth*—A pain in the left side, coming on two or three days before menstruation, and very often relieved when the flow commences.

Now, let us see what an examination reveals to us. The finger touches the cervix, and, on rocking the uterus backward and forward between one hand in the vagina, and the other on the abdomen, it is found to be perfectly in its normal position. On placing the patient on her side, and introducing the speculum, the vagina is found to be bathed in a discharge, and is in a condition of chronic inflammation. The cervix is found to be lacerated extensively. It has contracted somewhat, as the injury is an old one; but I can almost pass my finger up to the os internum. I could not map out the left ovary distinctly, but, on pressing the broad ligament in the situation the ovary ought to occupy, it was found very sensitive to pressure. Clasping the ovary between the hands is not always practicable; but in this case it is highly probable that the pain produced by pressure is due to chronic ovaritis.

What accounts for the leucorrhœa? On the introduction of Sims' speculum, we saw what is commonly called a large granular ulcer. This condition is not, however, an ulcer; it is the cervix uteri which has been entirely laid open and exposed by the laceration. To this condition is due the leucorrhœa.

The fixed backache is likewise due to this cause. The exposed surface of the cervix is very tender, and in a neuralgic condition. It is in just the same state as the lower eyelid would be in a patient suffering from ectropion. It is a delicate part, and not intended to such exposure. Any irritation or inflammation produced pain in the exposed surface. The pain in the back is a reflex neuralgia transmitted to the spine. You often see the same thing in other parts of the body. The remains of an old tooth in the jaw often gives pain in the eye.

It now only remains to discover the cause of the fourth symptom. What is the sterility due to? The discharge is quite sufficient to destroy the function of the zoasperms. We not only find sterility in such a case as the present, where the cervix is lacerated, but even when there is only a slight inflammation in the cervical canal. The discharge in this case is of a very ichorous character, and is quite enough to cause the spermatozoa to lose their vitality. When the seminal fluid, taken from the vagina, is examined a short time after coition, it is found full of devitalized zoasperms.

Here, then, we have everything from which this patient suffers accounted for. Now as to the treatment, which, of course, is intended to relieve her symptoms. Let us begin with the first one, the leucorrhœa. How can we relieve it? Only in one way, and not by treating the condition of the cervix as a granular ulcer, not by the hot iron, nitrate of silver, nitric acid, etc., but simply by restoring the cervix to its original normal condition. The vaginitis and vulvitis may be let alone, as they are but secondary results of the ichorous character of the discharge from the cervix. Remove the cause of the trouble, and you cure it.

Now as to the sterility. The same answer applies here. It may be a long time before these symptoms are relieved, perhaps six months or more, but eventually they will all disappear, when their cause is removed. Now as regards the condition of the ovaries. The state in which they are at present, it is highly probable, is due to the traumatism, and is reflex in character. When the cervix is restored, the condition will probably be relieved, but if it is not, we may then try galvanism, counter-irritation, rest, etc.

I imagine some of you are already asking, would I not use vaginal injections? I would, but I would not rely on them. Suppose a dentist finds a tooth giving rise to supra-orbital neuralgia, he might certainly advise local applications, but if he acted intelligently, he would first remove the cause of the difficulty. He would treat the result afterwards. You may say that I am now talking as a lecturer, but let me say that I would speak to you in the same way in my office, in private. This woman will certainly get well if the lacerated cervix be attended to in the proper way. Unfortunately, we cannot operate here, and, in this woman's circumstances, it would not be advisable to do so at home, but she may go into the hospital, as we shall endeavor to persuade her, and there she shall be attended to.

Uterine Hæmorrhage after Abortion.

The next patient presents a condition similar in its *pathology* to the last one in some respects, though as you will see the *symptoms* are different.

Mrs. Hannah S., aged 40, native of Ireland, married twenty years. Has had ten children and one miscarriage. The miscarriage happened the last time she was pregnant, which was three months ago. Her confinements have all been pretty easy labors except the last one, which was about three years ago. She has been sick for the last three months, in other words, since her miscarriage. She complains chiefly of flooding. She also says that occasionally something seems to loosen in her throat, and then falls down. This is probably one of those obscure reflex nervous troubles that are so frequently seen in uterine disease. She likewise complains of great weakness, and is afraid to do any housework for fear her strength will give way. She could attend properly to her work before three months ago, but since that time she has flooded continually, and has lost considerable blood. If you look at her face, you see how pale and weak she looks, and you see right away that she must have lost a quantity of blood. The pulse is weak and rapid.

Now, gentlemen, you have heard her history. The tenth labor, three years ago, was the hardest of all. Three months ago she had a miscarriage and has been an invalid ever since. She has lost blood, not only at her menstrual periods, but all through the month.

Examination shows that the perineum is ruptured all the way down to the sphincter ani. The vagina is long and flabby, and there is slight rectocele. There is a large sub-involuted vagina which has grown lax and feeble from many parturitions, and the injury inflicted on the perineal body. Here is a woman who, according to her own story, has been well and suffered no inconvenience for three years, for at least it must date from her last labor, with this condition of the perineal body, while the cervix uteri is in the same condition as it was in the patient who has just gone out. She has never had violent leucorrhœa, and yet she has the same condition of things that produced it in the previous case. Here also, the uterus is in a condition of complete subinvolution. What was the cause of this? Perhaps it was not the laceration, for it did not cause it before the miscarriage took place. She has then, laceration of the cervix, subinvolution of the uterus, subinvolution of the vagina, and rupture of the perineal body, four conditions closely connected with each other, but yet she has not suffered near so much in comparison to the pathological state of her organs as the previous patient. Here is a contrast which often occurs, and it teaches an important lesson. In gynecology do not look for mere pathological facts, but for pathological conditions which give rise to symptoms from which the patient suffers. You may find a fibroid tumor in the uterus, but it may occasion no inconvenience and have nothing to do with the symptoms for which a patient seeks relief, though it may be curious and interesting as a pathological fact.

But let us return to our case. This laceration, although it certainly exists, has not much relation to this woman's symptoms, and it is not the trouble for which she seeks our aid. Its cure will not, perhaps, relieve the other, and at present more important conditions. In this case let the cervix alone. Sew it up and do nothing more, and she will be just as bad as she was before. The hæmorrhage, which is her real trouble, may still continue, and she will have a just right to say that you have done her no good.

The woman comes to be relieved of certain symptoms which she has related to you, and your duty is to find out what is the cause of the hæmorrhage. The condition of the cervix is not causing it, as that has been there at least three years. The rupture of the perineum has nothing to do with it. The subinvolution of the vagina may likewise be excluded. It must have been something that occurred at her miscarriage. This is in all probability some alteration in the mucous lining of the uterus. In such cases it may be necessary to dilate the cervix with a sponge tent and examine the uterus, but do not use the sponge tent unless you are forced to do so. It is a decidedly dangerous method of proceeding. Some years ago I used to use the sponge tent very frequently, and would speak of them carelessly and flippantly, regarding their use as a matter of little moment, but since then I have seen too many cases of cellulitis, too many cases of death following their use to talk about them flippantly now. Of course I have not entirely discarded their use; I employ them when necessary, but I recognize their danger, and am cautious.

The cause of this hæmorrhage might be a piece of placenta still remaining in the uterus, it might be no larger than the smallest joint of one of the fingers. About six weeks ago, a patient came from Highland Falls to consult me, and complained of a hæmorrhage after a miscarriage. I sent her home for the time being, gave her some ergot to take and told her to come back. She did not do so, but at the end of about a week sent me a piece of placenta which had been cast out by means of the ergot, and the hæmorrhage was cured. Such a cause might be at work here, and if so it might be necessary to employ the sponge tent.

The most common cause of such a hæmorrhage, however, and I speak, having in mind the results of a long experience, is a fungous growth in the mucous membrane of the uterus. So the first thing you should do is to take a copper wire curette by which you can scrape out the cavity of the uterus, but you can never do any injury to it. This instrument is entirely harmless, as it bends on the slightest pressure. In this case I used it, and said to my assistant at the time, that if we found nothing, we should have to use the sponge tent.

Here you see the result of the operation and the cause of the hæmorrhage. Here are a number of fungoid growths, that we scraped out of the uterus. They are hypertrophic elongations of the lining membrane of the uterus, little polypi. It may be that if they were left in situ, they would become true polypi, but of this I have no proof. Now, if I get all of these growths out of her uterus, the hæmorrhage will be entirely relieved.

How about the perineum and cervix. Well, we may cure them, but why should we operate if she does not suffer from them? Suppose all these fungoid growths are removed, she will get entirely rid of her hæmorrhage and will soon recuperate and regain her health and strength. She thinks she would be entirely well if this hæmorrhage were stopped. The thought comes into your mind how much better she would be if perineum and cervix were restored, but remember that it was not on their account that she sought relief, but if after all she thinks their restoration would benefit her, then you may attend to them.

PRURITUS VULVÆ.

The next case that I shall show you is one of very long standing, and also one that is very commonly met with, yet the more books and authorities you consult in regard to it, the worse off you will generally be, there are so many divergent opinions concerning its pathology, and so many different ideas as regards it treatment.

Mrs. M. C., aet. 50, native of Ireland, married 26 years, has had seven children and one abortion. The last child was born seven years ago. She says she has been sick for twenty-six years, so I think we are right in calling the case a chronic one. She has but one symptom and that is an excessive itching of the vulva. This pruritus vulvæ is so bad that it is the bane of her existence, and if you cannot give relief, and very frequently you cannot, you can see what a terrible bane it is. The itching is sometimes so bad that it keeps her awake for hours at night, and she is obliged to scratch herself almost all the time. She passed the change of life, or, as we call it, reached the meno-pause a year ago, but this made no difference in the condition of the parts. She has been much worse at various times than she is at present. She says she has no itching in other parts of her body.

Now let me tell you what an examination showed us. The patient being placed upon the back, the finger placed in the vulva. The labia majora were found to possess exquisite sensibility, the slightest touch giving pain. The finger being carried into the vagina, a free leucorrhœal discharge is found. The uterus has undergone physiological atrophy at the meno-pause, but the cervix is found uncommonly large, and when the speculum is introduced it is found to be the seat of intense inflammation, and the vagina likewise is in a similar condition. All the parts around the vulva are almost in a condition of eczema, the surface is so intensely red. The constant scratching with the nails has tended greatly to aggravate this condition. Now what is the cause of this pruritus, for that is what we must seek for; the pruritus being only a symptom produced by some cause that we must find out, if we can.

Some years ago a woman came here almost wild from loss of sleep and opium eating. The parts were terribly excoriated with the nails, and were in a fearful condition. In her case, I ran over all the causes and could not fix on any of them, and finally thought of diabetes. I obtained some of her urine and had it examined, and it was found to contain sugar.

I simply mention this case to tell you and to impress upon you the fact, that you must always look for a specific cause. If you look at your books and glance over the number of prescriptions given for this symptom, and perhaps choose one of them, such as biborate of soda, or bichloride of mercury, and order it to be applied, you will have done just nothing at all for your patient in most cases. Sometimes by looking at once for the cause, you can cure a case instantly that has lasted for months.

Sometimes in looking carefully, you may find pediculi in patients in whom you would least suspect them. In such a case a single application would be sufficient to relieve the patient. In many cases the pruritus is continually aggravated by the constant scratching with the nails.

I simply wish to call your attention to the absolute necessity of discovering a cause for this distressing malady.

Another cause that is not so frequent as those I have mentioned is true eczema. If this be the condition giving rise to it, do not treat the pruritus, but the eczema itself. Give arsenic, recommend proper diet and hygienic habits, keep the skin in constant activity, and the symptom will disappear, but under no local applications would it be cured. Other skin diseases may likewise be the cause, but if so, treat them and not the pruritus.

The most frequent of all causes is vaginal leucorrhœa, and there is a peculiar kind of vaginal leucorrhœa that is extremely liable to cause it. The discharge in such cases is extremely ichorous and irritating. I do not know the true cause of this peculiar quality, but it is so marked that sometimes even on your finger it will cause irritation, and it often requires considerable washing to prevent this irritation. On coition this discharge may give rise to gonorrhœa in the male. A true urethritis may be set up, which, however, is not usually so bad as a specific gonorrhœa as shown in the comparative ease with which it yields to treatment.

Sometimes this leucorrhœa is but slight in amount, but still it is extremely irritating. It is amply sufficient to cause irritation and excoriation of the vulva as I have often proved to my satisfaction. If you wish to test the truth of this, simply tampon the vagina thoroughly for a short time and the patient will get relief. The discharge is thus dammed up and cannot come in contact with the parts to excoriate them.

What is the pathology of this case? The eczema of the vulva and thighs is due to this woman's nails. The constant scratching here, kept up for twenty-six-years. accounts for it easily enough.

Now as to the treatment. 'Tamponning the vagina will not cure the case, and local applications will not do it for the simple reason that none of these means will stop the cause. The cause of this leucorrhœa must be removed, and this is a difficult thing to do. It may be impossible to cure it, but, at any rate, we can give some relief. I suspect there may be a polypus in this cervix, because it is so large, there may not be, however, and there may only be an inflammation.

We will give her biborate of soda as a vaginal injection, and once or twice a week we will expose the cervix, clean it thoroughly and touch it with a strong solution of nitrate of silver, or nitric acid, in the hope of changing the character of the inflammation. Then we will use a vaginal injection, and push up a large suppository containing five grains of gallic or tannic acid. This will prevent the free flow of ichorous mucus from the cervix and vagina. When this much is done for the cause of the trouble, then we may treat its results. These may be removed by your local applications outside, whatever one you give preference to, whether it be biborate of soda, or bichloride of mercury, or any of the others, it matters not which.

ORIGINAL ARTICLES.

REMARKS ON HYSTERIA.*

BY
FRANK P. FOSTER, M. D.,
Physician for Diseases of Women to the Out-Patient Department of the New York Hospital.

Mr. President and Gentlemen—The sketchy and disjointed character which you will remark in what I have to say is to be attributed to its hasty preparation—hasty from my having consented, at short notice, to supply a deficiency in the series of papers for our meetings.

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* Read before the Medical Journal Association, December 21, 1877.

In regard to the symptoms of the disease, nothing need be said of the convulsive form, for it is sharply enough defined and well described by a great number of writers. As to the other manifestations, however, my own observation leads me to think that well-marked globus is less frequent than would be inferred from most descriptions of the disease, whilst the reverse is the case with regard to pain and syncopal attacks. The pain to which I refer is well known as being more commonly situated in the back, (with tenderness over the lumbar, sacral, and coccygeal vertebræ,) in the hypogastrium, in one or both iliac regions, particularly the left, in the left infra-mammary region, in the epigastrium, in the occiput and nuclea, and in the neighborhood of the sacro-iliac synchondrosis of one or the other side—the frequency of its occurrence in these various localities following the order in which they are here enumerated.

In maintaining the frequency of syncopal attacks, I do not refer to seizures of well-marked syncope, although these are common enough in hysterical subjects, but to attacks of what may be called abortive syncope. The phenomena may be described as follows: The patient suddenly feels a horrible sense of impending unconsciousness, but full loss of consciousness never takes place. If standing or walking, she (or he, for this manifestation is almost equally common in the two sexes,) always feels as if she were about to reel and fall, (not to fall suddenly,) and frequently seizes some object, as a chair or railing, to support herself. Sometimes she actually falls, but she is always able to break the force of her fall by voluntary efforts and to call intelligibly for help. By an intense exertion of the will many patients are able to overcome the disposition to fall, and to conceal their apprehension of falling, but they cannot in the slightest degree avert the other phenomena of the seizure, although they may sometimes shorten their duration by a rapid succession of deep inspirations. These other phenomena are, a sudden pallor of the face, occurring at the onset of the attack, followed instantaneously by flushing of several minutes' duration; and, at the same time, a feeling as if the heart were about to stop beating, which also is only momentary and is followed by increased strength, but not usually by acceleration of the cardiac pulsations. These are the unvarying phenomena, but occasionally certain additional ones take place, such as choreiform twitchings of the muscles of the face or the upper limbs, always feeble, scarcely attracting the notice of a looker-on, and never tonic spasms. Exceptionally the seizure is preceded by an aura, generally referred to the hypogastrium. Many of these patients are more liable to be attacked when present at an assemblage of people, (notably at church, and more particularly upon changing from the kneeling to the standing posture,) and I am inclined to think that the dread of an attack under such circumstances is a powerful agent in determining its occurrence. A few are generally attacked soon after retiring to bed, but in such the seizure may always be prevented by the use of a moderate alcoholic drink.

The pathology of hysteria has been the subject of no little dispute. On the one side are ranged those who, whether trammeled by the etymology of the word and the fanciful traditions which have come down to us from remote antiquity, or by that over-wheening absorption in a specialty which, even in this nineteenth century, leads men to repeat the old dictum, "*propter uterum est mulier quod est*," see in hysteria nothing but a train of symptoms directly dependent upon some disease of the genital organs. On the other side we find the strict neurologists, who, in my opinion, err just as widely in looking upon hysteria as an essential neurosis entirely independent of disease elsewhere than in the nervous system, and whose speculations as to aberrations of nervous force, etc., are little less grotesque than the ancient idea that the uterus was capable, in its autonomy, of retiring from the pelvis in disgust, and betaking itself to the gullet, there to tease and vex its unfortunate owner. It seems to me that the truth lies between the gynæcologists and the neurologists. I do not think that a brief and at the same time satisfactory definition of hysteria can be given, but I think that we may say that hysteria is an abnormal condition of the nervous system, in one or more of its parts, either inherited or acquired; that the reason of its manifesting itself almost exclusively in the female, is that its tendencies are more in consonance with the natural workings of the womanly than with those of the virile organism, and that therefore it meets in the former with less physiological (and in many instances with less volitional) resistance than in the latter; that it thus constitutes a latent predisposition to the phenomena which we recognize as hysterical—which phenomena may be evoked by emotional disturbances or by mal-nutrition, rarely, however, unless aided by positive physical disease in some part of the body, generally within the pelvis or the abdomen—notably the former. Such disease may be of little moment in itself. Indeed, my observation leads me to agree with those who state that hysteria is more apt to be developed by the slighter than by the severer diseases of the abdominal and pelvic contents—or rather, I would say, by those affections which, while they may ultimately prove serious, are for the time being giving rise to little, if any, local manifestation of trouble. Such disease may be nothing more than functional, for I have seen well-marked hysterical symptoms subside at once, never to re-appear, upon relieving a distended colon.

As to the element of perversity, I believe that it exists much more rarely than many physicians seem to think. True, many of the manifestations of hysteria may be more or less controlled by an exertion of will on the part of the patient, but such exertion must be extraordinary in degree, such as we have no right to expect from an enfeebled and long-suffering woman. Under the influence of some unusual stimulus, such as the dread inspired by the mention of some barbarous method of treatment, the patient may make such an extraordinary exertion of will, with the effect of overcoming the symptoms; and she is rewarded with the insinuation that she has been a maligner! Do we not all know that a drunken man may often be sobered at once by a profound and startling impression upon his mind? Are we, therefore, justified in assuming that his drunkenness was feigned? Great harm has been done by the undue stress which has been laid upon the power of the will to control hysterical symptoms, whereby the laity have imbibed the idea that to be hysterical involves a certain amount of culpability. The consequence is, that we are often debarred from giving to a woman who, far from wishing to magnify and prolong her ailments, is exceedingly anxious to be rid of symptoms which seem to her the harbingers of some dreadful brain disease, that consolation and encouragement which she ought to draw from the information that her malady is nothing more serious than hysteria; for, no sooner is this announcement made than she looks upon herself as being accused of a sort of fraud, and, being well aware of the groundlessness of such a charge, naturally feels hurt and seeks other advice.

In the treatment of hysteria, I regard it as of the first importance that the patient should be informed of the nature of the ailment, care being taken to disabuse her of the notion that any stigma attaches to the disease. We should not make light of her actual sufferings, but only of her gloomy forebodings. Careful search should be made for disease of any organ. As I have already stated, it will generally be found within the pelvis, and it should be made the subject of treatment, for, if neglected, it will seriously interfere with the effects of measures addressed to the nervous system, and moreover, in itself it demands attention, for diseases of the uterus show little or no tendency towards spontaneous recovery, but rather incline to become obstinate and serious. How absurd and hazardous is it to disregard the condition of the pelvic contents, and order exercise, on horseback, perhaps, when, at every step, an engorged uterus is dangling from a thickened broad ligament, and liable at any time to occasion an hæmatocele or some other serious accident.

Together with appropriate treatment of any local disease which may be discovered, the patient's general nutrition should claim careful attention. Hysteria has been looked upon as the result of luxurious living. The fact is, however, that it is more prevalent among the poor than among the rich. Far from reducing the diet, I think it is best to encourage the liberal use of the most nutritious food, provided it be easily digested, well assimilated, and the waste products of its metamorphosis duly voided. Alcohol, preferably in the form of spirit, is generally beneficial at one period, or another in the course of the affection, care being taken that the single doses shall not be large enough to produce flushing, headache, or other manifest effect. Cod-liver oil is also of great service. As regards drugs, I consider arsenic as altogether the most serviceable of those that I have used, but I confess that their number is few. For overcoming pain, it seems to me that electricity is the most useful measure, and I have found the galvanic current more efficient than the faradaic. In the few instances of hysterical convulsions in which I have employed pressure over the ovaries, I have not observed any effect from the proceeding.

As to the question of marriage, discussed by so many writers, I have never advised that measure, and I think that the cases must be exceedingly few in which such advice would be judicious. If there be disease of the uterus or its appendages, it is likely to be aggravated by marriage, and as to any benefit likely to be derived from gratification of the sexual desire, I wish to record my decided conviction that women, with very rare exceptions, are not much troubled with desire for sexual connection.

HOSPITAL RECORDS.

ROOSEVELT HOSPITAL, NEW YORK.

Reported by W. B. Berry, M. D., House Surgeon.

LIGATION OF THE FEMORAL ARTERY FOR FEMORAL ANEURISM—LISTER'S ANTISEPTIC METHOD—SERVICE OF DR. T. M. MARKOE.

John Murphy, Ireland, aet. 30, married, tailor. Patient states that sixteen years ago he first noticed a small pulsating swelling, size of walnut, on his right thigh. He locates it as then existing at upper limit of the patella, about two inches above the internal condyle of the femur. He says that while following his trade he continually used a heavy tailor's iron, which he rested on the lower end of his right thigh. He gives no other traumatic cause for the tumor. The swelling gradually grew larger, till two months ago, when it rapidly increased in size and became painful.

For last two weeks pain has been severe, and he has been unable to walk but a short distance, the power of using the limb suddenly giving out and compelling him to stop and rest. Family history good, and denies syphilis. On admission, there is well-marked pulsating tumor on anterior surface of lower end of right thigh. Its centre is just below a point over Hunter's canal, and is evidently an aneurism of femoral artery at this point. It extends well downward toward knee, pushing the patella down and outward. The tumor is well described seventeen and one-quarter inches in circumference, including the thigh, and about six inches in length. It is rather soft; ceases to pulsate on pressure on the femoral artery above, and in this condition can be much reduced in size by pressure.

There is a well-marked bruit over the tumor, extending up toward the artery.

There is no œdema of leg below, but the superficial veins are enlarged. Pulsation in both anterior and posterior tibial arteries is normal; *urine negative*. *Treatment*—Rest maintained in bed and patient put on liberal and nourishing diet.

October 19.—General health and tone improving. Size of tumor, (seventeen inches,) slightly diminished.

October 25.—Digital compression of femoral artery at Poupart's ligament and on inside thigh attempted, and after an hour's trial it was impossible to control the circulation, the arterial tension being so great. The attempt was given up, but the tumor became firmer and pulsated less. Size, same.

October 28.—Esmarch's bandage was put on from the toes over the tumor, well up on the thigh. The bandage was left on one-half hour and then removed, but circulation was stopped for one and one-half hours longer by the rubber cord, the patient being under ether. At the end of this time pulsation was decidedly less in the tumor, which was firmer.

October 29.—Pulsation in tumor about same as before. Esmarch's was applied. Tumor is firmer. Size, sixteen and one-half inches.

October 30, 3 p. m—Patient under ether. Ligation of femoral artery in Scarpa's triangle performed by Dr. Markoe, assisted by Dr. Sands: An incision three inches long was made over the sartorius muscle on inner side of the thigh. The skin, fat and connective tissue were at once cut through, exposing the sartorius muscle covered by its sheath with its fibres running diagonally across the thigh at the upper third. Its sheath was opened, the muscular fibres pushed aside, and the connective tissue on its posterior surface carefully cut through. The femoral artery then came into view, and could be felt and seen pulsating, being of large size. The sheath of the artery was then opened, with the back of the scalpel toward the vessel. The aneurism needle was then forced around the artery from within outward, and the carbolized gut ligature tied. In tying the ligature, only sufficient force was used to stop the circulation, but not enough to break the inner coats. Catgut sutures were used, the wound covered by the protective, and Lister's dressings applied.

The operation was done under carbolized spray and with all Lister's precautions; 6 p. m., pulse, 100, Temperature, 104°. Given hypodermic Magendie, eight minims.

October 31, 9 a. m.—Pulse 84, Temperature, 98¾°. Patient passed a comfortable night. Seems in very good condition. Wound was redressed. Slight serous discharge. Looking very quietly, indeed.

November 1.—Feeling "first-rate." Pulse and temperature about normal.

November 2.—Circulation in the leg very good. There is no œdema nor recurrent pulsation in the tumor. The aneurism sac feels firm, and size of tumor sixteen and one-quarter inches.

November 3.—Redressed. There is primary union along the whole face of wound. Discharge inconsiderable. Sutures left in. Patient with appetite good and in best of spirits.

November 5.—Complains of no pain. Size of tumor sixteen and one-eighth inches.

November 6.—Redressed. Gut sutures all softened off. Looking very quiet. Primary union seems firm. Lister renewed.

November 8.—Lister's dressing discontinued. Union perfect; cicatrix dressed with sheet lint and strap. There appears to be slight recurrent pulsation in the tumor, (nine days after ligation;) size same, sixteen and one-eight inches.

November 10.—Pulsation in the tumor more marked, but slight as compared to that before ligation. There is no pulsation in femoral below the seat of ligation.

November 13.—Size of tumor, fifteen and one-half inches.

November 16.—A flat bag of shot of ten pounds placed over the tumor, with ice bag applied to the shot.

November 17.—Pulsation slight. Size, fourteen and three-fourth inches.

November 26.—Pulsation still slight; size, about same, fifteen and one-eighth inches.

December 1.—Size same. Pulsation has ceased.

December 7.—Discharged; cured.

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EDITORIAL.

HEALTH OFFICER OF THE PORT.

This important office has virtually been vacant since the spring of 1875, when Dr. Vanderpoel's term expired. Ex-Governor Tilden at that time nominated Dr. Austin Flint, Jr., to fill the position, but on account of difficulties between the Governor and Senate, the latter declined to confirm the nomination. The governor failed to submit another name for approval, and consequently Dr. Vanderpoel continued in office until the inauguration of Governor Robinson. It was now hoped by the leaders of both political parties that the newly elected governor would settle the matter amicably, by presenting to the Senate the name of a person which it would confirm, but Mr. Robinson thought proper to submit the name which had been sent back to Gov. Tilden two years previously. There being every reason to believe, however, that the Senate would not confirm the nomination, Dr. Flint's name was withdrawn before it was acted upon. It was, however, sent a second time to the Senate by Gov. Robinson, who has again withdrawn it. So the matter rests to the present day, Dr. Vanderpoel filling the office until a successor shall be appointed.

As there is at present no probability that the Senate will confirm the nomination of Dr. Flint, many names are being urged upon the notice of Gov. Robinson, and it is to be hoped that he will present the most suitable one for confirmation at an early day.

In the choice of a candidate, the Governor should not be expected to rely upon his own knowledge of the medical profession, nor upon that of his cabinet, to decide upon the person best fitted to fill this important position, and we take it to be the duty of the profession, and medical press, to assist him in determining upon the abilities of those that may be urged for nomination.

The following names are rumored as being strongly pressed upon the Governor's notice at present: Dr. Austin Flint, Jr., of New York; Dr. Paine, of New York; Dr. Horatio Robinson, Jr., of Auburn; Dr. Wilder, of New York; Dr. Alex. Hutchins, of Brooklyn; Dr. Frank H. Hamilton, of New York; Dr. Wey, of Elmira; Dr. W. A. Hammond, of New York; and Dr. Jones, of Albany.

We fear that Mr. Robinson will fall into a very grievous error, if the rumor be true that he intends to nominate Dr. Paine, of this city, a homeopath, and for many years the family physician of the Governor. We commend the Governor's gratitude and friendship, but in filling such an important office as that of Health Officer of the Port of New York, friendships should not be considered. What the citizens want is to have the office speedily filled by a thoroughly capable and experienced man. If the Governor nominates for the office an unknown member of a school founded upon an exclusive dogma, he will just as certainly have the name of the candidate returned to him. To substantiate our statement, let him investigate the fate of the bills that have been presented to the legislature by the homœpathic school. Almost all of them have been defeated by the members of the scientific school of medicine. It is not our purpose here to discuss the justice or injustice of this course, we merely wish to point out the fact, in order that the Governor may take advantage of it. Our remarks apply with equal force to Dr. Horatio Robinson, Jr., of Auburn, a homeopath; and with still greater force to the name of Dr. Alex. Wilder, of this city, who is classed as an "irregular."

Of Dr. Hutchins and Dr. Jones we have little to say. They are unknown outside their own immediate circles, and although either of them might be able to fill the position satisfactorily, neither the profession nor the laity have ever had any evidence of their ability. Besides this Dr. Hutchins is a member of the Democratic party and we do not think the Governor would risk his name, suddenly brought from obscurity before a Republican Senate.

Dr. Wey, formerly Mr. Robinson's family physician, is, we believe, also a candidate for the nomination. He is undoubtedly a man of some ability, but he cannot bring with him that long experience in sanitary matters that such men as Hammond, Hamilton and Flint, can. We think, therefore, that Dr. Wey will have to retire to guard against being obscured by the greater lights.

We are now narrowed down to Drs. Hammond, Flint, and Hamilton, whose names, it is rumored, are at present very strongly urged. We doubt whether Dr. Hammond would consent to his name going before the Senate, and are quite certain that it would not be confirmed should it be sent there; and as regards Dr. Flint's fitness for the position we have not the slightest doubt. Thoroughly scientific, with an amount of energy and executive ability seldom seen in a profession like our own, we feel sure that, if Dr. Flint's name were confirmed, he would not fail to discharge the duties of the office to the entire satisfaction of the State. But it is now well-known that the Senate is not inclined to look favorably upon his nomination, and it consequently becomes necessary for the Governor to submit another name, and of those reported as having been brought to his notice, none is more worthy the honor than that of Prof. Frank H. Hamilton, of this city. This gentleman is too well-known, not only in this country, but throughout the civilized world, for us to call attention to his fitness for the position. Few men have devoted a life to their profession and humanity as wholly as he has. As an author, military and civil surgeon, and teacher, the profession has long since accorded him the highest rank. As a sanitarian we believe Dr. Hamilton has few equals, and no superior. His work upon "Military Surgery and Hygiene" gives evidence throughout of his keen observation of the causes of ill-health among the troops, and the paramount utility of the measures he adopted to bring about a reform. His experience as medical inspector during the war of the rebellion, and the reputation he then achieved as a sanitarian, resulted in the Commissioners of Public Charities and Correction of New York choosing him, during the cholera epidemic of 1866, as Chairman of the Committee of Medical Inspection. The manner in which he fulfilled the duties of this office is best shown by the following extract from the report of the Commissioners to the Legislature. In speaking of the cholera, they say, (*vide Seventh Annual Report, page 15*,) "And in this connection it is proper to advert to the invaluable services of Dr. Frank H. Hamilton. When the cholera broke out, isolated hospitals were at his instance and under his directions established, a code of sanitary regulations formed by him was adopted, and radical changes in diet, and in the forms and hours of labor, at his suggestion, were made. To his resolute and intelligent action may be attributed the arrest of the disease, and so confident was he of the efficacy of his proposed treatment, that he foretold the number of days in which the disease would disappear. The last case occurred within twenty-four hours of the period he had designated."

In addition to these facts, we may call attention to his efforts at reform in sanitary matters in this city, during the past two years, which have shown still further his clear views in regard to these matters, and an indomitable perseverance in carrying out his ideas.

If Gov. Robinson would consult both the wishes of the medical profession and laity, he would nominate Dr. Hamilton, as the most suitable of those who have been brought to his notice, and in our opinion the most capable person to fulfill the duties of the office. In addition to carrying out the wishes of the citizens in this matter, the

Governor would meet with no opposition from the Senate on party questions, the doctor being a Republican.

We sincerely hope that this matter will be amicably settled before long, and that the Governor will see fit to make a nomination which will adjust the difficulties existing between himself and the Senate, and at the same time give entire satisfaction to the citizens of the State.

PERISCOPE.

COLLABORATORS.

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RELATIONS OF OPHTHALMOLOGY TO GENERAL MEDICINE.

J. Hughlings Jackson, in his annual oration before the Medical Society of London, discusses at some length the Relations of Ophthalmology to General Medicine, noting the importance of discovering errors of refraction, and mentioning a case coming to Brudenell Carter with supposed cerebral disease, which was found to be simple myopia. In this case, the patient came to Mr. Carter, not on account of trouble with his eyes, but because he had heard that ophthalmic surgeons had an instrument useful in investigating brain disease. He instances also the case of a medical student affected with persistent vomiting and frontal headache; vision good, both for near and distant work, but hypermetropia and astigmatism existed, and when suitable glasses were supplied, the vomiting and headache stopped, and he resumed work after two years enforced idleness. Dr. Jackson thinks the evidences of neuritis from strain on the ciliary muscle in hypermetropia throw light on cases in which functional abuse leads to paralysis, as in writer's cramp, or in congestion and œdema of the brain from overwork. There is danger too, of mistaking for cerebral disease the giddiness, irregularity of gait and confusion of sight, arising from slight paresis of ocular muscles. This vertigo is not from diplopia, as so commonly supposed, but from false estimates of the position of objects by the affected eye; the position being judged of by the amount of nerve force exerted to bring the eye to bear on the object. If the object be upon the same side with the weak muscle, an unusual amount of nerve force must be employed to turn the eye toward it, and the brain, judging by the old standard, conceives the object to be much further removed from the median line, (in case of the paralysis of the external rectus,) than it really is. This vertigo is, physically considered, a *motor* symptom, not *sensory* as is commonly supposed. Also from what is called secondary deviation in paralytic strabismus, *i. e.*, over-action of one muscle when its paralyzed congener is sought to be brought into action, may be deduced a principle of nervous action, viz., that when a centre discharges itself and one route for the current is closed, the current flows in other directions, and thus the gait in locomotor ataxy may be explained. In speaking of the ophthalmoscope he says it should be used by routine in intra-cranial diseases, instancing optic neuritis as sometimes an early symptom of locomotor ataxy, and saying that the process of embolism may be here fully studied. (A good article on this subject by Noyes, of New York, may be found in the *American Journal of Medical Science*, for October, 1877.) Tubercles in the choroid in cases of acute tuberculosis may confirm a doubtful diagnosis, as may also the evidences of syphilitic choroiditis, (described by Hutchinson,) in cases of suspected hereditary disease. The well-known retinal changes in some cases of chronic Bright's disease are also mentioned, and attention called to the fact that though usually a late symptom it is not very uncommon for the ophthalmic surgeon to be the first to suspect renal disease, as the changes are generally found with the small kidney and not accompanied with dropsy.

S. B. St. J.

PIGMENT OF THE RETINA.

The coloring matter of the retina has recieved a great deal of attention at the hands of physiologists lately. Until recently, it was supposed that the retina was destitute of pigment, because when the eye is examined under ordinary conditions, none is found. Recent investigations have demonstrated the existence of a pigment highly sensitive to light, which discolors it. W. Kuhne, of the Phys. Inst. of the Univ. of Heidelberg, in the Klin-Monatsblätter für Augenheilkunde, says, "A colored rabbit was securely fastened opposite a square opening cut in a window shutter, the head covered for five minutes with a cloth, and then exposed for three minutes. The head was then cut off, and one eye enucleated under sodium light, and placed in a five per cent. solution of alum. After two minutes, the other eye was treated in the same way. The next morning the outside of the retina showed a clear square spot in the second eye, quite white; in the first, somewhat pink." In subsequent experiments, he got more perfect pictures of the window, showing the cross-bars of the sashes in delicate pink lines. He gives this process the name of optography.

In a later report, Kuhne announces the extension of his investigation to the human eye, in the case of a hospital patient who died in the night. Upon examination of the eye under sodium light, the pink coloring matter was found in abundance except at the macula. The pigment could also be recognized with the microscope.

Capranica Stefano (*Annales l'oculistiques*) finds the pigment insoluble in water, alkalies or acids, but soluble in alcohol, ether, chloroform or bisulph-carbon making a golden-yellow solution. Concentrated sulph. acid changes it to violet. Nitric Acid makes it blue and then decolorizes it. Solution of iodine changes it to green. These reactions are the same as those with pigment from birds and reptiles. The spectroscope shows two absorption bands, the bands being identical with solutions from frog, lizard and chicken. Spectroscopically and photo-chemically, this substance corresponds exactly with the luteine described by Hoppe-Seyler and Thudicum, and found in the corpus between the yolk of egg, the serum of blood, butter and adipose tissue, as well as some ordinary vegetable. Finally Capranica thinks he has found "that there exists already in the ovum a coloring matter, destined to enter into the composition of the future retina."

S. B. St. J.

OPTIC NEURITIS FROM LEAD POISONING.

Galezowski (*Recveil d' ophthalmologie*) describes a form of progressive atrophy of the optic nerve from lead poisoning, associated with muscular atrophy and paralysis. The lesions are caused by salts of lead lodged in the nerve tissue. The disturbances of vision resemble those of hysteria. The lesion is supposed to be in the brain and not in the optic nerve primarily, the optic neuritis being secondary. The same author advocates the use of the thermometer in ophthalmology, using an instrument small enough to go between the eye lids, and says that the eye undergoes more variatons of temperature than any other organ, and often without participation of any other organs. The temperature rises or falls one or two degrees, or even two and one-half degrees centrigrade, especially in the course of catarrhal conjunctivitis of iritis or irido-choroiditis. We cannot yet tell what may be the real value of its use. The normal temperature of the eye is thirty-six five-tenths and thirty-sixth seven-tenths. As general conclusions, he gives: *First*—The temperature of the eye increases eight-tenths to one degree in all affections with free discharge. *Second*—In certain inflammations of iris choroid and cornea the temperature is same as general temperature, or below it. *Third*—The temperature of the eye rises or falls as the disease aggravates or diminishes.

S. B. St. J.

VEREBÉLYI ON TREATMENT OF CONGENITAL CLUB-FOOT BY SUBPERIOSTEAL REMOVAL OF THE ASTRAGALUS.

(*London Medical Record*, November 1877.)

The author describes a case of double talipes in a child five and one-half years old. Tenotomy and the application of a plaster of Paris bandage having failed, the astragalus of one foot, which presented the principal obstacle to reduction, was laid bare by an incision, and, the periosteum having been stripped off, was removed. The foot was then brought into proper position, in which it was retained by a fenestrated plaster of Paris bandage, and afterward by a proper apparatus. After the healing of the wound, the foot easily preserved its proper direction. N. M. S.

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PIROGOFF'S OPERATION FOR CLUB-FOOT.

(*London Medical Record*, December 15, 1877.)

Dr. Weinlicher showed a patient to the Imperial Royal Medical Society of Vienna, on both of whose feet he had performed Pirogoff's operation, on account of a high degree of club-foot. In both instances he had fixed the os calcis to the bones of the leg by means of pegs, and thus produced anchylosis. Unfavorable circumstances delayed healing for two months in one foot, and three months in the other; and while the plastic result was good, the function of the limb was not restored, though improvement was to be expected. There was much tenderness in the heel. N. M. S.

◆

ERRATA.—In Dr. Hamilton's paper on "Alimentation in Surgical Accidents," etc., read before the Academy of Medicine, and published in the last number of this journal, page 32, fifteenth line, for "or of chronic," read *or of acute or chronic;* page 34, fifth line, for "one change," read *the change;* twenty-sixth line, omit "digestion and assimilation wait on appetite; page 35, seventh line, for "rich," read *sick;* thirty-second line, for "so far inferior," read *far inferior;* page 38, before the seventh paragraph, add, *I will make the following brief summary;* page 40, seventh proposition, read "morphine and *other* narcotics." There are a few other minor errata, which the reader will be able to correct himself.

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